MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8370)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 05088

1. PLACE OF DEATH:

County: ~~Annapolis Md~~

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 Day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 190 Clay Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Sadie Adams

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	Col	Divorced

6 (b) Name of husband or wife: Samuel Adams

6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): June 2 1886

8. AGE:

Years	Months	Days	If less than one day
53	11	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business:

FATHER
12. Name: Louis Sorrel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Lucial Bryan

Address: 19o Clay Street Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1940 (month) (day) (year)

Cemetery or crematory: Tannyard

Location: Shadyside Md.

18. Funeral director: B.L.Hopping

Address: Annapolis, Md

19. 5/15 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1940, to May 12, 1940, and that I last saw her alive on May 12, 1940.

Immediate cause of death: Cerebral Hemorrhage

Due to: Unknown

Due to:

Other conditions: Influenza

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: 2 hrs. 1 week

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other

Address: Annapolis, Md Date signed: 5/14/40.

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

05089

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Jones Station
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Balto + Annapolis R.R. tracks
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: R.F.D. Severna Park P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: near Jones Station
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Beatrice May Alton

3. (b) Social Security Number:

4. Sex: female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Carl L. Alton, Sr
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 15th 1915

8. AGE: Years: 24 Months: 11 Days: 9 If less than one day ____ hrs. ____ min.

9. Birthplace: West Annapolis
(Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Henry A. Oaksmith
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Nellie May Jones
15. Birthplace: A. A. Co. Md

16. Informant: Henry A. Oaksmith
Address: Jones Station. A.A.Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26th 1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. May 25 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1940, at 6 33 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem Examination 19__, to 19__, ~~and that I last saw the alive on~~ May 24 1940

Immediate cause of death: Fracture of neck
Fracture of left thigh, Fracture of ribs left chest, Fracture of upper and lower jaws left side.
Due to: Fracture of left humerous and shoulder.
Due to: Multiple deep lacerations
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 5/24/40
Where did injury occur? near Jones Sta. A.A. Md (City or town) (County) (State)
on B+A.R.R. Tracks
Injured at home, farm, industry, public place (where?): R.R. Tracks
Means of injury: Hit by R.R. train Injured at work? no

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other
Address: Annapolis Md Date signed: 5/25/40

RECEIVED
JUN 5 1940
BUREAU OF S.

05090

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 23

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE HEAVILY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

1 PLACE OF DEATH

County Anne Arundel (33-a)

Village or City Galley (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Emma Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)

6 DATE OF BIRTH: Not Known (Month) (Day), 1878 (Year)

7 AGE: 62 yrs. ____ mos. ____ ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Dan Jackson

11 BIRTHPLACE OF FATHER (State or country): Va.

12 MAIDEN NAME OF MOTHER: Isabella Lawns.

13 BIRTHPLACE OF MOTHER (State or Country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Anderson

(Address) Galley A A Co Md

15 Filed May 28 1940 Mabel P. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 26, 1940 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 22 1940 to May 26, 1940 that I last saw her alive on May 25, 1940 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH * was as follows:

Uterine Deferous prolapse of 4 days duration

Cerebral Hemorrhage

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Leon D. Adler M. D.

May 26 1940 (Address) 4700 Belmont

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contrsected, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Marley Neck Cem. DATE OF BURIAL: 5/28/40

20 UNDERTAKER: Sarah L Brown Ms ADDRESS: Montgomery

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory."

(Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

05091

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town (If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Bamboo

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County Anne Arundel

City or town (If outside city or town limits, write RURAL, NEAR and give town) Ward No.

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Julia A. Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widow

6.(b) Name of husband or wife Mary Anderson 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1875 Census

8. AGE:

Years	Months	Days	If less than one day
65	—	13	hrs. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Gardiner

FATHER 13. Birthplace Balto. Md

MOTHER 14. Maiden name Julia ~~M. Gardiner~~ Miller

MOTHER 15. Birthplace Balto Md

16. Informant Mary L. Anderson

Address Gambrills

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22-40 (month) (day) (year)

Cemetery or crematory Baltimore Memorial

Location Lutheran Cem. Brooklyn, Md.

18. Funeral director C. Bell Wiedefeld

Address Catonsville Md

19. 5/24/40 19 E. J. Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 40, at 6.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h— alive on — 19 —

Immediate cause of death Coronary Thrombosis — DURATION

Due to Post Mortem Diagnosis from history.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. K. Lippitt M. D. or other

Address Catonsville Md Date signed May 20-40

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

05092

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs. 9 mos. 7 das.

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 590 St. Mary's Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: MARTHA BAKER

3. (b) Social Security Number: -------

4. Sex: Female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry Baker

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1894 (?)

8. AGE: Years: 46? Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER
12. Name: Owen Watkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susie Pierce
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-10-46 (month) (day) (year)

Cemetery or crematory: Mt Aubrey Ct

Location: Balto Md

18. Funeral director: Isaiah L. Brown & Son

Address: 108 W Montgomery St

19. 5/7-40 (Date rec'd by registrar) 19 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7th 1940, at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. July 31st 1934, to May 7th 1940, and that I last saw her alive on May 7th 1940.

Immediate cause of death: Lobar pneumonia — DURATION: 6 das.

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations: -----
Of autopsy: ----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: Herb P. Smithwood M. D. or other

Address: Crownsville, Maryland Date signed: 5/7/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05093

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2yr.8mo.3days
Stay in this community (yrs., or mos., or days): 2yr.8mo.3days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 2433 Woodbrook Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: James Barrack
3. (b) Social Security Number: ---

4. Sex: Male
5. Color or race: Black
6. (a) Single, married, widowed, or divorced: Single
B (b) Name of husband or wife: unknown
--- 6(c) if alive, give age --- years
7. Birth date of deceased (mo., day, yr.): 1909
8. AGE: Years: 31 Months: Unknown Days: If less than one day: -- hrs. -- min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: None
11. Industry or business: ---
FATHER
12. Name: Richard Barrack
13. Birthplace: Virginia
MOTHER
14. Maiden name: Gertrude Waring
15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville State Hospital
17. (Burial, cremation, or removal. Which?) Date thereof: May 31 40 (month) (day) (year)
Cemetery or crematory: Lancaster Co. Va.
Location: Va.
18. Funeral director: Geo. G. Kelson
Address: 1303 Preestman St.
19. May 28 1940 (Date rec'd by registrar) E. F. Joyce DJ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1940 19 , at 1P.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24, 1937, to May 27 1940, and that I last saw him alive on May 27 1940.

Immediate cause of death	DURATION
Bilateral Pulmonary Tuberculosis	5/20/40
Due to Pulmonary Tuberculosis	
Due to ---	
Other conditions ---	
(Include pregnancy within 3 months of death)	
Major findings: Of operations ---	
Of autopsy ---	

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 5/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

05094

Reg. Dist. No. 23

1. PLACE OF DEATH:
County 9 Arundel Rd
City or town Brooklyn Pk AA Co Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A Co
City or town Brooklyn Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 9 Arundel Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Peter Bauer
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widower
6 (b) Name of ~~husband or~~ wife Carrie H Bauer
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 26 - 1854
8. AGE: Years 86 Months — Days 17 If less than one day hrs. min.
9. Birthplace Germany (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name ? Bauer
13. Birthplace ?
MOTHER 14. Maiden name ?
15. Birthplace Germany
16. Informant Mr Carl J Bauer
Address 9 Arundel Rd Brooklyn Pk AA Co Md
17. (Burial, cremation, or removal. Which?) Date thereof May 16 (month) (day) (year) 1940
Cemetery or crematory Loudon Pk
Location Baltimore Md.
18. Funeral director Jos. Jordens & Son
Address 1927 Park Ave.
19. May 15 1940 (Date rec'd by registrar) Mrs De Alba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5/13/40 19 , at 3:28 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/27/ 1940, to 5/13 1940, and that I last saw him alive on 5/12/40 19
Immediate cause of death
Pneumonia, Hypostatic
Due to
Due to Hypertensive cardiovascular disease
Other conditions apoplexy
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M. D. or other
Address 203 Catapsco Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(170-C)

05095

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A.A.
City or town: Parole Rural Near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 9 Years 18

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 13 Colonial Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Benjamin Raymond Brashears

3. (b) Social Security Number: 214-05-0508

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec 3 1921
8. AGE: Years 18 Months 5 Days 10 If less than one day ____ hrs. ____ min.
9. Birthplace: Parole (Town, county, and state)
10. Usual occupation: Baker
11. Industry or business
FATHER
12. Name: Ben R. Brasears
13. Birthplace: Mayo
MOTHER
14. Maiden name: Bessie B. Lewis
15. Birthplace: Maryland
16. Informant: Mrs Bessie Brashe ars
Address: Parole Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1940 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md.
18. Funeral director: B.L.Hopping
Address: Annapolis, Md.
19. 5-15 1940 (Date rec'd by registrar) J J Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 9 A 30 M
21. I CERTIFY that death occurred on the date above stated; ~~Date attended for examination~~ Post-mortem examination
~~and that I last saw the case alive on~~ 19
Immediate cause of death: Fracture of neck
Fracture of ribs
~~Due to~~ C puncture of lungs
Fracture of right
~~Due to~~ femur
Other conditions: due to (Auto-mobile Collision)
(Include pregnancy within 3 months of death)
Major findings: —
Of operations
Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of 5/13/40
Where did injury occur? near Parole, Anne Arundel Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway #2
Means of injury: Auto-Collision Injured at work? no
23. SIGNATURE: John M. Caffey Deputy medical examiner M. D. or other
Address: Annapolis Md Date signed 5/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15 (M) (I) (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

05096

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Annapolis Harbor
Stay in hospital or inst. (yrs., or mos., or days): 0
Stay in this community (yrs., or mos., or days): 0

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: near McDaniel Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Samuel A. Brown

3. (b) Social Security Number: 217-09-4907

4. Sex: male
5. Color or race: negro
6. (a) Single, married, widowed, or divorced: married
8 (b) Name of husband or wife: Annie Brown
6(c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): June 29 1904

8. AGE: Years: 35 Months: 10 Days: 20 If less than one day: hrs. min.

9. Birthplace: Md Trappe Talbot
(Town, county, and state)
10. Usual occupation: Seaman
11. Industry or business:
FATHER 12. Name: Geo Brown
13. Birthplace: Trappe Talbot Co
MOTHER 14. Maiden name: Martha Turner
15. Birthplace: Trappe Talbot Co
16. Informant:
Address:
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Claiborne Md
Location:
18. Funeral director: Norman Marshall
Address: St. Michaels Md.
19. 5/9/ 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1940 at after 12:05 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem 19 to examination May 9 1940
Immediate cause of death: Drowning
Due to: fall from ferry-boat
Due to: Gov. Ritchie
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: accident Date of: 5/1/40
Where did injury occur? Annapolis Harbor Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ferry-boat
Means of injury: drowning Injured at work? no
23. SIGNATURE: John M Claffey Deputy medical examiner M. D. or other
Address: Annapolis Date signed: 5/9/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

05097

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Annapolis Ward No. 1
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Randall Court.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Wirt Burwell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Elliott Burwell
6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 20th 1886

8. AGE: Years	Months	Days	If less than one day
54	1	29	hrs. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Wirt Randall
FATHER 13. Birthplace Annapolis Md.
MOTHER 14. Maiden name Hannah Parker Parrott
MOTHER 15. Birthplace New Burg - N. Y.
16. Informant Elliott Burwell
Address Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21st 1940 (month) (day) (year)
Cemetery or crematory St Annes
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 5-20 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1940, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1940, to May 18th 1940, and that I last saw h em alive on May 18 1940.

	DURATION
Immediate cause of death Acute Dilatation of Heart	5-18-
Due to Generalized Carcinomatosis	
Due to Primary carcinoma of breast. Duration - three years.	
Other conditions C.W.S.R.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George O Burwell M. D. or other
Address Annapolis Md. Date signed 5- 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

05098

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town near Hanover

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Hanover Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Harry Henry Butler

3. (b) Social Security Number

4. Sex Male

5. Color or race Col

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rachel Burley

6(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 88 Months ? Days ? If less than one day ___ hrs. ___ min.

9. Birthplace near Hanover, A.A.Co. Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farmer

FATHER 12. Name Jack Butler

13. Birthplace Unknown

MOTHER 14. Maiden name Margaret Anderson

15. Birthplace Unknown

16. Informant Rachel Butler (wife)

Address Hanover Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12-1940 (month) (day) (year)

Cemetery or crematory St Marks

Location Near Hanover A.A.Co.

18. Funeral director The W.C. White Co. Inc

Address Laurel Md

19. May 11 1940 (Date rec'd by registrar) Clara M Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 4 45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 16 1940, to May 10 1940, and that I last saw him alive on May 9 1940.

Immediate cause of death Chr. Myocarditis — DURATION 1 yr

Due to General arteriosclerosis — 9 yr.

Due to Left Hemiplegia — 1 mo

Epilepsy — 9 yrs

Other conditions Senility — 9 yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A B Brumbaugh M. D. or other

Address Elkridge Md Date signed 5/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-8)

05099

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Mayo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: ------
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: LOUIS BUTLER

3. (b) Social Security Number: -----

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or wife~~: Sarah Butler, wife

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1898 ?

8. AGE: Years: 42 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 5/30/40 (month) (day) (year)

Cemetery ~~or crematory~~: Holy Cheese Cem

Location: South Rover Md

18. Funeral director: J. A. Hardesty & Son

Address: Galesville Md

19. May 28 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28th 1940, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22nd 1940, to May 28th 1940, and that I last saw him alive on May 28th 1940.

Immediate cause of death: General paralysis of the insane

DURATION

Due to

Due to

Other conditions: Lues

(Include pregnancy within 3 months of death)

Major findings: ------

Of operations

Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: Robert P. Kinkrads M. D. or other

Address: Crownsville, Maryland Date signed: 4/28/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(95-d)

Reg. Dist. No. 11 05100

1. PLACE OF DEATH:

County: A.A.

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 28 Gotts Court

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 30 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 28 Gotts Court
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: William W. Butler

3. (b) Social Security Number: 218-01-4389 (Pass)

4. Sex: M

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eliza Butler

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Feb 17 1875

8. AGE: Years: 65 Months: 2 Days: 13 If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Louis Butler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknow n

16. Informant: Eliza Butler

Address: 28 Gotts Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1940 (month) (day) (year)

Cemetery or crematory: Brewerhill

Location: Annapolis, Md.

18. Funeral director: B.L.Hopping

Address: Annapolis, Md.

19. May 7th 1940 (Date rec'd by registrar) F. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1940, at 8.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1940, to May 3 1940, and that I last saw him alive on April 30 1940.

Immediate cause of death: Chr. myocarditis c decompensation — DURATION: yrs. 1 mo.

Due to: Hypertension c Arteriosclerosis — yrs.

Due to: Senility

Other conditions: Amputation st. leg. L. Hemiplegia — old.
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice F. Klawans Md
M. D. or other

Address: 31 Smith Gate av Date signed: 5/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 13 1940
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (110-C)

CERTIFICATE OF DEATH

05101

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: South River Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Near Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Best Gate
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Gloria Elain Carson
3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 19th 1922
8. AGE: Years 17 Months 11 Days 24 If less than one day hrs. min.
9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: School girl
11. Industry or business
FATHER
12. Name: George Carson
13. Birthplace: Phila Pa
MOTHER
14. Maiden name: Ruth A. Miller
15. Birthplace: Annapolis Md.
16. Informant: George Carson
Address: Best Gate A.A.C. Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof May 15th 40 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. 5 15 1948 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 9 30 A.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination, ~~and that I last saw him or alive on~~ May 13 1940
Immediate cause of death: Depressed fracture of entire right side of skull
Compound fracture of ulnar ~~[illegible]~~ and radius right side
Due to: Collision of automobile and truck on South River Blvd. 2 miles ~~[illegible]~~ North of South River Bridge
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of 5/13/40
Where did injury occur? Parole (City or town) A. A. Co (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway #2
Means of injury: auto. collision Injured at work? No

23. SIGNATURE: John M. Claffy Deputy Medical examiner M. D. or other
Address: Annapolis Date signed 5/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05102

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville, Maryland
Stay in hospital or inst. (yrs., or mos., or days): 6 mos. 20 days
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: 1420 McCulloh Street Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: MICHAEL CARVALLIO

3. (b) Social Security Number: Unknown

4. Sex: male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ---------
6(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 57 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/7 - 40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.
18. Funeral director: Supt
Address

19. May 7 1940 (Date rec'd by registrar) E. F. Joyce D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3rd 1940, at 6A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13th 1939, to May 3rd 1940, and that I last saw him alive on May 3rd 1940

Immediate cause of death: Syphilis — DURATION: ?
Due to
Due to
Other conditions: Bullet in skull — 8 mos
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury: ----- Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 5/3/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

05103

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Holly Beach Farm

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Nr Annapolis Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Holly Beach Farm

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Edward Clasby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Julia Clasby

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1887

8. AGE:

Years	Months	Days	If less than one day
53	9	26	hrs. min.

9. Birthplace Lexington Ky.
(Town, county, and State)

10. Usual occupation Horse trainer

11. Industry or business and Breeder Farmer

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Julia Clasby

Address R.F.D. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3d (month) (day) (year)

Cemetery or crematory

Location Lexington Ky.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. May 2nd 1940 (Date rec'd by registrar) F. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1940, at 8Q M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 1 1940, and that I last saw him alive on May 1 1940.

Immediate cause of death	DURATION
Coronary occlusion	1 day
Due to Chronic Myocarditis	1-2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.

M. D. or other

Address Annapolis Md Date signed 5/1/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

05104

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County A. A.
City or town Annapolis Md Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Conduit St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Agnes Cole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edward Cole
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 83			hrs. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name
FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace

16. Informant Arthur Cole
Address Conduit St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23rd 1940 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md
18. Funeral director John M. Taylor
Address Annapolis Md.

19. 5-24-1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1940, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 40 to May 20 1940, and that I last saw h[illegible] alive May 20 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Murphy M. D. or other
Address Annapolis Md Date signed 5-24-40

RECEIVED
JUN 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

05105

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospt
Stay in hospital or inst. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 11 Brewer Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alfred Basil Cole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Stella Cole
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 16th 1866

8. AGE:

Years	Months	Days	If less than one day
73	11		____ hrs. ____ min.

9. Birthplace A. A. Co Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Thomas Cole
13. Birthplace A. A Co Md
MOTHER 14. Maiden name Willis Sut
15. Birthplace A. A. Co Md
16. Informant Mrs Irene Ellinghausen
Address 11 Brewer Ave Annapolis Md
17. Burial Date thereof May 18 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory All Hallows
Location Davidsonville Md
16. Funeral director John M. Sayler
Address Annapolis Md
19. May 17 1940 J. J. Myers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1940, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1940, to May 16 1940, and that I last saw him alive on May 16 1940.

	DURATION
Immediate cause of death Cerebral Hemorrhage	5-15-40
Due to Hypertension Arteriosclerosis	years
Due to	
Other conditions Diabetes Mellitus	years

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo O Bond M. D. or other
Address Annapolis Md Date signed 5-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (77-C)

05106

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rock Point, Pasadena P.O
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: off St. Smallwood Road
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rock Point, Pasadena P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: off St. Smallwood Rd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: — —

3. (a) FULL NAME: William Francis Corcoran Jr

3. (b) Social Security Number: 412-03-4934

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: - S

6 (b) Name of husband or wife: None
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 4 - 1915

8. AGE: Years 24 | Months 4 | Days 15 | If less than one day ___ hrs. ___ min.

9. Birthplace: St Louis Mo. (Town, county, and state)
10. Usual occupation: Welder
11. Industry or business: Maryland Drydock Co.

FATHER
12. Name: William Francis Corcoran
13. Birthplace: Unknown

MOTHER
14. Maiden name: Estella —
15. Birthplace: Unknown.

16. Informant: From Papers Found among effects
Address:

17. Ship (Burial, cremation, or removal. Which?) Date thereof May -2, 1940 (month) (day) (year)
Cemetery or crematory:
Location: Memphis Tenn.
18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md.

19. May 2, 1940 (Date rec'd by registrar) Mrs DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1940, at 12 A M about 30

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination, ~~and that I last saw him alive on~~ May 1, 1940.

Immediate cause of death: Alcoholism (acute) — DURATION: 4 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: John M. Claffey Deputy Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 5/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

05107

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hosp.

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Weems Creek Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Garden Farm (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Norman Westly Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elise D. Davis

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 7th 1879

8. AGE:

Years	Months	Days	If less than one day
61	2	27	hrs. min.

9. Birthplace Easton Md (Town, county, and state)

10. Usual occupation Electric Wireman

11. Industry or business Naval Exp Station

FATHER 12. Name Wm W. Davis

13. Birthplace Maryland

MOTHER 14. Maiden name Jean Wright

15. Birthplace Delaware

16. Informant Elise D. Davis

Address Garden Farm A.A.Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7th 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluffs

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 5-6th 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 4 1940, and that I last saw him alive on May 4 1940.

Immediate cause of death Tobar Pneumonia — DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H Hopkins M.D. M. D. or other

Address Annapolis Md Date signed May 6/40

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MAY 16 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (940)

05108

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anna Arundel County
City or town: Jessup, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, ~~hospital~~, or institution: Maryland House of Correction
Stay in ~~hospital~~ or inst. (yrs., or mos., or days): 6 Months & 3 days.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 3727 Nortonia Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Frederick E. Denhard

3. (b) Social Security Number: 212-05-6854

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 26, 1892

8. AGE: Years	Months	Days	If less than one day
47	11	22	13 hrs. 45 min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business: Rustless Iron & Steel
FATHER
12. Name: Emil Denhard
13. Birthplace: Germany
MOTHER
14. Maiden name: Dorothea Denhard
15. Birthplace: nee Feldner
16. Informant: Mr. Elbert E. Denhard
Address: 2708 Chelsea Terrace
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 40 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto. Md
18. Funeral director: Wm. J. Tickner & Sons
Address: North & Bl. Aves
19. May 19 (Date rec'd by registrar) 1940 Clara M. Kasluff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19th, 1940 19 , at 1.45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from P.M. May 12, 1940, to May 19, 1940, and that I last saw him alive on May 19, 1940.

Immediate cause of death: Coronary occlusion
Due to:
Due to:
Other conditions: Bronchitis
Paralysis of left vocal cord
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION: 6 mo.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. R. Turnpt, M. D. M. D. or other
Address: Maryland House Correction Date signed: 6/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 23 1946
BUREAU V. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05109

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 9 mos. 28 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: XXXXX

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1509 N. Mount Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --------

3. (a) FULL NAME: MARY DIGGS

3. (b) Social Security Number: ------

4. Sex: Female

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 62 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER 12. Name: John Diggs

13. Birthplace: Virginia

MOTHER 14. Maiden name: Lizzie Burgers

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 2, 1940 (month) (day) (year)

Cemetery or crematory: West Moreland County

Location: Virginia

18. Funeral director: George G. Kelson

Address: 1303 Freisman Pl

19. 5/29 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28th 1940, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1939, to May 28th 1940, and that I last saw her alive on May 28th 1940.

Immediate cause of death: Hypertensive cardiovascular Disease

Due to:

Due to: Cerebral hemorrhage

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: -------

Of autopsy: ------

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work? -----

23. SIGNATURE: Wm. J. Mitchell M. D. or other

Address: Crownsville, Md. Date signed: 5/28/40

RECEIVED
JUN 4 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05110

1. PLACE OF DEATH (93-d)

County A. A. Registration Dist. No. 22

Village or City Jessup No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Bertha A. B. Disney If U. S. Veteran, specify WAR

(a) Residence: No. Jessup Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. W. Disney Jr.

6. DATE OF BIRTH (month, day, and year) Apr 22 - 1865

7. AGE Years 75 Months 1 Days 2 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Samuel Watts

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Sarah Gardner

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Mrs L. L. Wilson (Address) Jessup Md

18. BURIAL, CREMATION, OR REMOVAL Bethel Cem. Camp Meade Date May 27 1940

19. UNDERTAKER Lloyd Kaiser (Address) Laurel Md.

20. FILED May 27, 1940 Clara M Haslup Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 24 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 21, 1940, to May 24, 1940

I last saw her alive on May 24, 1940; death is said to have occurred on the date stated above, at 11 30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Bronchopneumonia — Date of onset 5-21-40

Other Contributory Causes of importance: Myocarditis, Chronic; Duration: ten years. — 11/30/39

Name of operation — Date of

What test confirmed diagnosis? P.E. Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify J. M. Warren

(Signed) M. D.

(Address) Laurel Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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JUN 6 1940
BUREAU V. S.

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-5

CERTIFICATE OF DEATH

05111

Reg. Diat. No. 22

1. PLACE OF DEATH:

County Anne Arundel County

City or town Jessup, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland House of Correction

Stay in hospital or inst. (yrs., or mos., or days) 1 yr-4 Mon/ 21 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 580 St Marys St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Mary Doyle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B (b) Name of husband or wife unknown

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-?

8. AGE:

Years	Months	Days	If less than one day
25			hrs. min.

9. Birthplace Durham, N. C.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name John Hart
13. Birthplace Durham, N. C.

MOTHER
14. Maiden name Anne Hart--Smith
15. Birthplace Durham, N. C.

16. Informant House of Correction
Address Jessup, Md.

17. Burial Date thereof May 29-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Jessup Md

18. Funeral director N L Coelyn

Address Jessup Md

19. May 29 1940 Clara M Haslup
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th, 1940 19 9.45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 27, 1940, to May 26, 1940, and that I last saw her alive on May 26, 1940.

Immediate cause of death	DURATION
Adenocarcinoma of uterus	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. R. Tunnyt, M.D.
M. D. or other

Address M. H. C. Date signed 5/27/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

05112

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Arnold.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Arnold Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henrietta Stockman Driver

3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife R. Thomas Driver
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 13th 1865
8. AGE: Years 74 Months 7 Days 5 If less than one day hrs. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Henry Dengel
13. Birthplace Germany
MOTHER 14. Maiden name Sophie Weller
15. Birthplace Germany
16. Informant Mrs W. S. Evans
Address Arnold. A.A.Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21 1940 (month) (day) (year)
Cemetery or crematory Jessup's M. E. Church
Location Cockeysville Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 5-20 1940 (Date rec'd by registrar) J. M. Carpel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1940, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1940, to May 17 1940, and that I last saw h en alive on May 17 1940.

Immediate cause of death Myocarditis & Myocardial Insufficiency (Chr.) — DURATION May 17th unknown
Due to Arterio Sclerosis
Due to Hypertension — unknown
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bail M. D. or other
Address Annapolis Md Date signed 5.19.40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05113

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 yrs. 8 mos. 24 days

Stay in this community (yrs., or mos., or days) 2 yrs. 8 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 2222 N. Howard St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Alfred Embank

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE:

Years	Months	Days	If less than one day
30	?	?	____ hrs. ____ min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Porter

11. Industry or business —

FATHER 12. Name Robert Embank

13. Birthplace Virginia

MOTHER 14. Maiden name Fannie ?

15. Birthplace Unknown

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-30-40 (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location Baltimore, Md.

18. Funeral director Adolphus Halstead

Address 918 Druid Hill ave. Baltimore, Md.

19. 5/26 1940 E. J. Joyce
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1940, at 2.35 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 1937, to May 26, 1940, and that I last saw h[illegible] alive on May 26, 1940.

	DURATION
Immediate cause of death General Paralysis of the Insane	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark J. Thompson M. D. or other

Address Date signed

RECEIVED
MAY 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

Reg. Dist. No. 2 05114

1. PLACE OF DEATH: A.A.

County

City or town Parole Rural Near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) ~~14~~ Years 9

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 13 Colonial Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frances Sarah Fertitta

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 1933

8. AGE: Years	Months	Days	If less than one day
17	1	23	hrs. min.

9. Birthplace Balto Maryland
(Town, county, and state)

10. Usual occupation School Girl

11. Industry or business

FATHER
12. Name Sanuael Fertitta
13. Birthplace Itally

MOTHER
14. Maiden name Eulah Staylor
15. Birthplace Balto, Md.

16. Informant Samuael Fertitta
Address 13 Colonial Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16 1940 (month) (day) (year)

Cemetery or crematory St marys

Location Annapolis, Md.

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 5 15 1940 (Date rec'd by registrar) J. A. Murphy Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1940, at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post. mortem examination ~~and that last saw~~ ~~alive in~~ 19

Immediate cause of death Fracture of neck
Fracture of skull
~~Due to~~ Fracture of pelvis
Fracture of femure
~~Due to~~ Fracture of both jaws
Due to Auto - collision

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Accident Date of 5/13/40
Where did injury occur? Near Parole (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway #2
Means of injury Auto - Collision Injured at work? No

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other
Address Annapolis. Md Date signed 5/14/40.

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-a)

05115

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anarundel

City or town: Laurel
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: District Training School

Stay in hospital or inst. (yrs., or mos., or days): 9 yrs 3 mos

Stay in this community (yrs., or mos., or days): 9 yrs 3 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anarundel

City or town: Laurel Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)

Street No. no other address
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Edward Fox.

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored.

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 21, 1914.

8. AGE: Years: 26 Months: 3 Days: 29 If less than one day: — hrs. — min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business: None.

FATHER
12. Name: Moses Fox.
13. Birthplace: Unknown

MOTHER
14. Maiden name: Madeline Johnson
15. Birthplace: Unknown

16. Informant: Hospital Record

Address: District Training School

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 5/20/40
(month) (day) (year)

Cemetery or ~~crematory~~: Dist. Train. School

Location: " " "

18. Funeral director: Dr James Lerwald.

Address: Dist. Train. School.

19. May 20 1940 (Date rec'd by registrar) Clara M Hasbefr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/20/40 1940, at 1:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1940, to May 20 1940 and that I last saw him alive on 5/20/40 1940.

Immediate cause of death: Tuberculosis left hip & pelvis — DURATION: 8 mos

Due to

Due to

Other conditions: Bronchopneumonia — 1 wk.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Tuberculosis left femur (head.)
Of autopsy: Not done.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; No

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: James Hurley M.D.
M. D. or other

Address: Dist. Train. School Date signed 5/20/40

RECEIVED
JUN 6 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

05116

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Annerundel.

City or town: Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 54 Clay St

Stay in hospital or inst. (yrs., or mos., or days): Emergency Hospital

Stay in this community (yrs., or mos., or days): 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a-a

City or town: Annapolis Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 54 Clay St Annapolis Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rachel Hall.

3. (b) Social Security Number

4. Sex: Fem

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or ~~wife~~: Edgar Hall

Dead 6(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 90. Months: - Days: - If less than one day: - hrs. - min.

8. Birthplace: West River a-a-Co (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: at Home.

FATHER

12. Name: Edward Taylor

13. Birthplace: West River a-a-Md.

MOTHER

14. Maiden name: Rachel Taylor

15. Birthplace: West River a-a-Co-Md.

16. Informant: William Eastern

Address: 54 Clay St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10 1940 (month) (day) (year)

Cemetery or crematory: Brewerhill Cemt

Location: Annapolis Maryland

18. Funeral director: E. H. B. Parker

Address: 47 Washington St

19. 5/9th (Date rec'd by registrar) 1945 J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1940, at 3:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1940, to May 8 1940, and that I last saw her alive on May 8 1940.

Immediate cause of death: bilateral (lower) lobar pneumonia.

DURATION: 1 wk. (?)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Df operations

Df autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Bernards M D M. D. or other

Address: Hotel Md Bldg. Annapolis Md Date signed: May 9 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (89-a) Reg. Dist. No. 21

CERTIFICATE OF DEATH

05117

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Jacobsville
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Jacobsville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Henrietta Handy

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: female

5. Color or race: negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Frank Handy

6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 10, 1887

8. AGE: Years 52 | Months 11 | Days 2 | If less than one day ____hr. ____min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER
12. Name Isiah Pack
13. Birthplace Md.

MOTHER
14. Maiden Name Laura
15. Birthplace Md.

16 (a) Informant Frank Handy
(b) Address P.O. Pasadena, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5-15-40 (month) (day) (year)
(c) Cemetery or crematory Magothy Cem.
Location A. A. Co.

18 (a) Funeral director James Hayes
(b) Address Baltimore

19 (a) 5-12-40 (Date rec'd by registrar) (b) L. A. Brett Registrar

MEDICAL CERTIFICATION

20. Date of death May 12th 19 40 at 9 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1936 to May 19 40 and that I last saw him alive on April 26 19 40.

	Duration
Immediate cause of death Cerebral hemorrhage	6 weeks
Due to Arteriosclerosis	indefin.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Brett. M.D. (M. D. or other)
Address Pasadena Date signed 5-12-40

RECEIVED
JUN 5 1920
BUREAU S. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05118

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 63 Washington St

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 63 Washington St
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Still-born infant Harris

3. (b) Social Security Number:

4. Sex: female

5. Color or race: negro

6. (a) Single, married, widowed, or divorced: —

B (b) Name of husband or wife: —

— 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 24, 1940

8. AGE: Years | Months | Days | If less than one day: hrs. 0 min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Raymond Rees
13. Birthplace: Camp Parole Md

MOTHER
14. Maiden name: Janie Harris
15. Birthplace: Annapolis Md

16. Informant: Janie Harris
Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/25/40 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis Md

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 5 25 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1940, at 3 A M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem Examination, ~~[illegible]~~ May 24 1940

Immediate cause of death: Still-born

Due to: Pre-maturity (8 mos)

Due to: Congenital lues

Other conditions:

(Include pregnancy within 8 months of death)

Major findings:

Of operations: —

Of autopsy: —

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis Md. Date signed: 5/24/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05119

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Mulberry Hill
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County A. A.
~~City or town~~ Mulberry Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Annapolis P.O.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard Tolbert Hawkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Lola Hawkins
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 25 1874

8. AGE: Years	Months	Days	If less than one day
66	4	6	____ hrs. ____ min.

9. Birthplace A. A.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John A. Hawkins
13. Birthplace A. A.
MOTHER 14. Maiden name Nancy Hawkins
15. Birthplace A. A.
16. Informant Mary Johnson
Address Mulberry Hill
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15/40 (month) (day) (year)
Cemetery or crematory Broadneck
Location Severn
18. Funeral director B. Johnson
Address Annapolis
19. 5-14 19 40 J. J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH May 11 19 40, at 10:50 M

21. I CERTIFY that death occurred on the date above stated; ~~that I last attended deceased on~~ Post-Mortem to Examination ~~deceased was last seen by me on~~ 19 ____

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Arterio Sclerosis.	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE John M. Caffey Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 5/14/40

RECEIVED
JUN 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05120.

Reg. Dist. No. 21

1. PLACE OF DEATH:
County a - a -
City or town Churchton a a co Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Churchton Md.
Stay in hospital or inst. (yrs., or mos., or days) No.
Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County a - a -
City or town Churchton. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. - Rural -
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Murray Hutton

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	Col	Married

6 (b) Name of husband or wife John Hutton
6(c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1869

8. AGE:

Years	Months	Days	If less than one day
70	7	16	— hrs. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business at Home
FATHER 12. Name Edward Chew.
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Rebecca Chew.
15. Birthplace Baltimore Md.
16. Informant Edward Murray.
Address 1631 Division St Balt-Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Franklin May 26 1940
Location Churchton Md.
18. Funeral director E. H. B. Parker.
Address 47. Washington St
19. 5 25 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940, at 6 9. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death Arteriosclerotic heart disease (Coronary sclerosis) — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Samuel M. Reichel M.D.
M. D. or other
Address Annapolis, Md Date signed May 23, 40

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BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05121

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 yrs. 7 mos. 10 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Spencerville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -------

3. (a) FULL NAME: LEWIS JOHNSON #2

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	black	single

6 (b) Name of husband or wife: ------

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 30 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Caleb Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Carrie Dorsey
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 1940 (month) (day) (year)

Cemetery or crematory: Spencerville Md

Location: Spencerville

18. Funeral director: Robt. L. Snowden

Address: Rockville Md

19. 5/30-40 (Date rec'd by registrar) 19__ E. F. Joyce DR Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30th 1940, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20th, 1936, to May 30th 1940, and that I last saw him alive on May 30th 1940.

Immediate cause of death: Bilateral pulmonary tuberculosis

DURATION

Due to

Due to

Other conditions: -------
(Include pregnancy within 3 months of death)

Major findings: ------

Of operations

Of autopsy: ------

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 5/30/40

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BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05122

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 years, 4 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: At Large

City or town: Marion Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: WILBUR JONES

3. (b) Social Security Number: -------

4. Sex: Male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -----

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 27 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER: 12. Name: John Jones

13. Birthplace: Maryland

MOTHER: 14. Maiden name: Della Jones Dennis

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 5/18-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt.

Address:

19. 5/18- 1940 (Date rec'd by registrar) E. F. Joyce Registrar

D L

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11th 1940, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7th 1938, to May 11th 1940, and that I last saw him alive on May 11th 1940.

Immediate cause of death: Pulmonary tuberculosis

Due to:

Due to:

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings: -----

Of operations:

Of autopsy: -----

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? (City or town) (County) (State) -----

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? ----

23. SIGNATURE: Herb T. Winkrodt M. D. or other

Address: Crownsville, Md. Date signed: 5/11/40

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BUREAU V. S.

05123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 82 Clay
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jessie J Larkins

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 29 1871

8. AGE: Years	Months	Days	If less than one day
69	3	23	____ hrs. ____ min.

9. Birthplace: Annapolis
(Town, county, and state)

10. Usual occupation: Nursemaid

11. Industry or business

FATHER
12. Name: William T Larkins
13. Birthplace: St Margarets Anne Arundel Co

MOTHER
14. Maiden name: Annie Elizabeth Larkins
15. Birthplace: Anne Arundel Co

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: On Washington Rd. outside Annapolis Md.

18. Funeral director: Charles H. Alexander

Address: 43-45 Northwest St. Annapolis Md.

19. 5-25 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23rd 1940, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 1940, to May 23rd 1940 and that I last saw her alive on May 23rd 1940

Immediate cause of death: Acute Myocarditis — DURATION: 5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: 110 - Clay St. Annapolis Md. Date signed: 5/24/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M) (I) (T)

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (308)

05124

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 months, 20 days

Stay in this community (yrs., or mos., or days): -------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1118 West Lafayette Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: HUGHES LEAKE

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	black	married

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1903

8. AGE: Years: 37 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: May 28. 40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Md. Balto. Md

18. Funeral director: Thomas E. Kelson

Address: 1303 Preston St.

19. 5/25 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1940, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4th 1939, to May 24th 1940, and that I last saw him alive on May 24th 1940.

Immediate cause of death: General paralysis of the insane

Due to:

Due to: Lues

Other conditions:

(Include pregnancy within 8 months of death)

Major findings:
Of operations: ------
Of autopsy: ------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 5/24/40

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

05125

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T) (M)

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn Grove

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn Grove Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Lewis Magruder Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 19th 1923

8. AGE:

Years	Months	Days	If less than one day
17	9	2	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER

12. Name: John Lewis Magruder

13. Birthplace: Alexandria Va

MOTHER

14. Maiden name: Mabel Ferris

15. Birthplace: Helena, Montana

16. Informant: John L. Magruder

Address: Severn Grove R 4 C Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington D. C.

18. Funeral director: John W. Taylor

Address: Annapolis Md.

19. 5-23-1940 (Date rec'd by registrar) J. J. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1940, at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1940, to May 20 1940, and that I last saw him alive on May 20 1940.

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Cervical Abscess Tuberculous	4 months

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Tuberculous adenitis and dup cervical abscess

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert S. G. Welch M.D. M. D. or other

Address 86 State Circle Annapolis Md. Date signed 5/22/40

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JUN 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05126

1. PLACE OF DEATH

County Anne Arundel (97) Registration Dist. No. 26

Village or City Churchton No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Annie Maitland If U. S. Veteran, specify WAR

(a) Residence: No. ___ St., ___ Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James Maitland

6. DATE OF BIRTH (month, day, and year): August 10, 1846

7. AGE: Years 93 96 | Months 8 | Days 29 | If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: domestic

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): A. A. Co. Md.

FATHER

13. NAME: Alexander Franklin

14. BIRTHPLACE (city or town) (State or country): Md.

MOTHER

15. MAIDEN NAME: Margaret Ann Norman

16. BIRTHPLACE (city or town) (State or country): Md.

17. INFORMANT (Address): John Dawson Churchton, Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place: St. James Cemetery Date: May 11, 1940

19. UNDERTAKER (Address): Robert J. Wood Friendship, Md.

20. FILED: May 9, 1940 J. B. Dent Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 9 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from January, 1938, to May 9, 1940

I last saw her alive on May 7, 1940; death is said to have occurred on the date stated above, at 4:00 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Senility	
Primary cause Arterio-sclerosis.	
C.W.R.	

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ___

(Signed) Samuel M. Reichel M.D. M. D.

(Address) 1 Munroe Ct., Annapolis, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 05127

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 day

Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Rural near Mitchellville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Robert Crain Highway, near Defense Highway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Marsteller

3. (b) Social Security Number

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1940

8. AGE: Years | Months | Days | If less than one day 7 hrs. 40 min.

9. Birthplace Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation not employed

11. Industry or business

FATHER
12. Name John Marsteller
13. Birthplace West Creek, N.J.

MOTHER
14. Maiden name Margaret Freeman
15. Birthplace Kinston, N.C.

16. Informant John Marsteller
Address Mitchellville, Md

17. (Burial, cremation, or removal. Which?) Date thereof May 12 40 (month) (day) (year)

Cemetery or crematory

Location Mitchellville Md

18. Funeral director John A Marshello
Address Mitchellville Md

19. 5-11 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1940, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3:20 A.M. May 11 1940, to 11 A.M. May 11 1940, and that I last saw her alive on May 11, 1940.

Immediate cause of death: Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel M. Reichel M.D.
M. D. or other

Address 1 Munroe Ct., Annapolis, Md Date signed 5/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1A

RECEIVED
JUN 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05128

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (83a)

County Anne Arundel Co. Registration Dist. No. 25

Village or City Brooklin ~~Vill~~ Park No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Emma S. Miller

(a) Residence: No. 107 5th. Ave. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Miller

6. DATE OF BIRTH (month, day, and year) Mar. 20-1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86	2	1	

OCCUPATION

8. Trada, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. X

10. Data deceased last workad at this occupation (month and year)

11. Total tima (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto.

(State or country) Md.

FATHER

13. NAME Frederick Reese

14. BIRTHPLACE (city or town) Pa.

(State or country)

MOTHER

15. MAIDEN NAME Sarah Wicklein

16. BIRTHPLACE (city or town) Pa.

(State or country)

17. INFORMANT Ida G. Haddaway

(Address) 107 5th. Ave.

f8. BURIAL, CREMATION, OR REMOVAL

Place Mt. Carmel Cem. Date May 24 1940

f9. UNDERTAKER John G. Miller

(Address) 2334 Jefferson St.

20. FILED May 26, 1940 Ida M. Whitam

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 21 (Month) 7 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1937 to May 21, 1940

I last saw h- alive on 5-20, 1940; death is said to have occurred on the date stated above, at 5-A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	May 17, 1940
Arteriosclerosis	?

Othar Contributory Causes of importanca:

Senility	

Nama of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Lawrence M. Sera M. D.

(Address) 1009 Annapolis Blvd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

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JUN 1 1928
BUREAU V.A.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05129

Reg. Dist. No. 21

1. PLACE OF DEATH:

County W. A. Co

City or town Davidsonville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State — County —

City or town — Ward No. —

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Eugie Mitchell

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis Mitchell

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 75 | Months: dont know | Days: dont know | If less than one day: — hrs. — min.

9. Birthplace: Lothian Md (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER

12. Name: Wm Adams

13. Birthplace: Lothian

MOTHER

14. Maiden name: Betty Johnson

15. Birthplace: Mexico

16. Informant: Louis Mitchell

Address: Davidsonville

17. (Burial, ~~cremation, or removal. Which?~~) Date thereof: June 2 40 (month) (day) (year)

Cemetery ~~or crematory~~: Davidsonville Cem

Location: Davidsonville Md

18. Funeral director: E. H. B. Parker

Address: 47 Washington St

19. 5 31 1940 (Date recd by registrar) J. H. Merrill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1940, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1940, to May 29 1940, and that I last saw her alive on May 29 1940.

Immediate cause of death: Generalized arterio sclerosis

Due to

Due to

Other conditions: Malnutrition

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. H. Fidler M. D. or other

Address: Davidsonville Date signed: 5-31-40

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05130

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days): 5 weeks
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 7 Cathedral St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Rae Emily Moore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Bertram D. Moore
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 23rd 1898

8. AGE:

Years	Months	Days	If less than one day
41	8	23	hrs. min.

9. Birthplace: St Marys Co. Md
(Town, county and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Charles A. Brady
13. Birthplace: Pri Geo Co Md.
MOTHER 14. Maiden name: Catherine J. VanDoyke
15. Birthplace: Pennsylvania N. J.
18. Informant: Bertram D. Moore
Address: 7 Cathedral St. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19-1940 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. May 17th 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1940, at 11:30 P. M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 15 1940, to May 15 1940, and that I last saw her alive on May 15 1940.

	DURATION
Immediate cause of death: Myocardial Insufficiency	5/1/40
Due to: Acute regatating endocarditis	3 wks
Pneumococcic Septicemia	3 wks
Due to: Branchio Pneumonia	4 wks
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings: None
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Willis Martin M.D.
M. D. or other
Address: Annapolis Md Date signed: 5/16/40

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JUN 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

05131

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County A. A.

City or town Eastport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 512 Third St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Mueller

3. (b) Social Security Number

4. Sex M

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1940

8. AGE: Years — Months — Days — If less than one day hrs. min.

9. Birthplace Eastport Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Bryan Mueller
13. Birthplace Kt.

MOTHER
14. Maiden name Mary E. Price
15. Birthplace Laurel Md.

16. Informant Helen Fitzgerald
Address 512 Third St Eastport

17. Burial Date thereof May 31st 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md

18. Funeral director John M. Taylor
Address Annapolis Md.

19. May 31st 1940 J J Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 1940, at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Stillborn

Due to Prematurity

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Linhardt MD
M. D. or other

Address Eastport, Md Date signed 5-31-40

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JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

05132

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or insl. (yrs., or mos., or days): 6 yrs.6 mos.2 das.

Stay in this community (yrs., or mos., or days): -------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: REBECCA FRANCES MURRAY

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	blakk	widowed

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
52	Unknown		____ hrs. ____ min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: General

FATHER
12. Name: Willis Hall
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Green
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

19. Funeral director: Supt.

Address: Crownsville Md

19. 5/22/40 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20th 1940, at 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18th 1933, to May 20th 1940, and that I last saw her alive on May 20th 1940.

Immediate cause of death: LOBAR PNEUMONIA of the right lung — DURATION

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --------

Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of: ____

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ____ Injured at work? -----

23. SIGNATURE: Mark J. Monrad M. D. or other

Address: Crownsville, Md. Date signed 5/20/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170d.

05133

CERTIFICATE OF DEATH

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Sandboles P.O.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crain Highway near Conoway

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Seat Pleasant Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 305 Oakmont Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alfred Wayne Norris

3. (b) Social Security Number: 577-20-9968

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife: Ethel L. Norris

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 9, 1910

8. AGE:

Years	Months	Days	If less than one day
30	0	26	____ hrs. ____ min.

9. Birthplace: Johnson City, Tenn. (Town, county, and state)

10. Usual occupation: Social Security clerk

11. Industry or business: U. S. Govt

FATHER

12. Name: Alfred Taylor Norris

13. Birthplace: Unicoi, Tenn.

MOTHER

14. Maiden name: Nollie Gibbs

15. Birthplace: Bakersville, N. C.

16. Informant: Ethel L. Norris Seat Pleasant Md.

Address: 305 Oakmont Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland, P. G. Co. Md.

18. Funeral director: W. W. Chambers Co.

Address: Riverdale, Md.

19. 5 5 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4, 1940, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated: Post Mortem Examination

May 4 1940

Immediate cause of death	DURATION
Fracture of Skull	Sudden
Broken Neck	
Hemorrhage	
Due to being thrown from standing motor cycle on which he was	
Due to operating	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

If autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide: accident. Date of: May 4, 1940

Where did injury occur? Conoway, Sandboles P.O. Pr. G. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Crain Highway

Means of injury: Thrown from motor cycle Injured at work? No

23. SIGNATURE: John M. Caffy Deputy Medical Examiner M. D. or other

Address: Annapolis Md Date signed: 5/4/40

RECEIVED
MAY 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

05134

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 11 days
Stay in this community (yrs., or mos., or days): ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown

3. (a) FULL NAME: BEN NORWOOD

3. (b) Social Security Number: Unknown

4. Sex: Male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ------
6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years: 73 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Florida (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: -----

FATHER
12. Name: ------
13. Birthplace: -----

MOTHER
14. Maiden name: ------
15. Birthplace: -----

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/28 - 40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt
Address

19. May 28 1940 (Date rec'd by registrar) E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25th 1940, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14th 1940, to May 25th 1940, and that I last saw him alive on May 25th 1940.

Immediate cause of death: Hypertensive heart disease due to generalized arteriosclerosis
Due to
Due to
Other conditions: Cerebral hemorrhage
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ------
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ---- Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 5/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-E)

CERTIFICATE OF DEATH

05135

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Ann Arundel Co.
City or town Hanover P.O. Near Harman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: life
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Ann Arundel
City or town Hanover P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ada Margaret Owens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1912

8. AGE: Years 27 | Months 10 | Days 15 | If less than one day hrs. min.

9. Birthplace Hanover P.O. A.A.Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Robert E. Owens.
13. Birthplace A.A.Co. Md.

MOTHER 14. Maiden name Katherine Lotz
15. Birthplace Howard Co. Md.

16. Informant Mrs. Alvis Owens.
Address Hanover P.O. A.A.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June. 2. 1940 (month) (day) (year)
Cemetery or crematory Friendship Cem.
Location near Harmans, A.A.Co., Md.

18. Funeral director William J. Tuckner & Sons
Address Arch & Pennsylvania Ave

19. May 31 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1931, to April 30 1940
and that I last saw h alive on April 28th 1940

Immediate cause of death Aortic Regurgitation — DURATION 9 yrs.
Due to Mitral Regurgitation — 9 yrs.
Due to Cardiac Decompensation — 1 month
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud Shipley M.D.
Address Savage, Md. M. D. or other
Date signed 5/31/40.

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-m)

05136

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Park
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: off road Belle Grove Rd at 4th Ave

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Rodger Thomas Pedroni

3. (b) Social Security Number: 192-05-4445.

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian Padroni (nee Hasse)

6(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): January 25, 1907

8. AGE:

Years	Months	Days	If less than one day
33	3	26	hrs. min.

9. Birthplace: Philadelphia, Pa
(Town, county, and state)

10. Usual occupation: Steel worker

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Lillian Padroni

Address: 1934 Chesapeake Ave. Fairfield

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24, 1940 (month) (day) (year)

Cemetery or crematory: Holy Cross Cemetery

Location: Anne Arundel Co. Md.

18. Funeral director: Lilly & Zeiler, Inc.

Address: 403 S. Wolfe St. Baltimore, Md.

19. May 23 1940 (Date rec'd by registrar) Matilda R. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1940 about 4 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination ~~[illegible]~~ May 21, 1940.

Immediate cause of death: Suicide

Due to: Carbon-monoxide gas

Due to: from auto exhaust

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Suicide Date of: May 20, 1940

Where did injury occur? Brooklyn Pk. (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) near Belle Grove Rd at 4th Ave

Means of injury: Carbon monoxide gas injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical Examiner M. D. or other

Address: Annapolis Date signed: 5/21/40

RECEIVED
JUN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

05137

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County Baltimore

City or town Charlestown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Ba. Co.

City or town Charlestown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Edward R. Phipps

3. (b) Social Security Number none

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nellie R. Phipps

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 16 1869

8. AGE: Years 70 Months 4 Days 20 If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore (Town, county, or state)

10. Usual occupation Retired Painter

11. Industry or business

FATHER 12. Name Wm. E. Phipps

13. Birthplace Charlestown, Md.

MOTHER 14. Maiden name Laura Levy

15. Birthplace Baltimore, Md

16. Informant Chester Phipps

Address Charlestown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 8 40 (month) (day) (year)

Cemetery or crematory Loudon Cemetery

Location Catonsville, Md

18. Funeral director T. A. Hardesty & Son

Address Catonsville

19. May 8 1940 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION 9 15

20. DATE OF DEATH May 6, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 5 1940, to May 6 1940, and that I last saw h alive on May 6 1940

Immediate cause of death: Cerebral Hemorrhage

Due to Hypertension

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Dent M. D. or other

Address Govans Date signed 5/7/40

RECEIVED
JUN 5 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05138

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr. 3 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: 77 Water St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Louise Raicks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1938

8. AGE: Years	Months	Days	If less than one day
2	3	17	hrs. min.

9. Birthplace: Annapolis (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Leon Raicks
13. Birthplace: Pappe Md.
MOTHER 14. Maiden name: Melvina Hopkins
15. Birthplace: Annapolis Md.
16. Informant: Melvina Raicks
Address: 77 Water St. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-31-40 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Dr. Washington Rd. outside Annapolis Md.
18. Funeral director: Charles H. Alexander
Address: 43-45 Northwest St. Annapolis Md.
19. 5-31 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1940, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/25 1940, to 5/29 1940 and that I last saw h[illegible] alive on 5/29 1940

Immediate cause of death	DURATION
Broncho-pneumonia	4 days
Due to: La Grippe	7 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lawrence W. Greene M. D. or other
Address: Annapolis Date signed: 5/31/40

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

05139

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Bay Ridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Lake Ogleton

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist. of Columbia County:

City or town: Washington Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Madison St. N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Francis Regan

3. (b) Social Security Number: — — —

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 30th 1925

8. AGE: Years: 14 Months: 10 Days: 25 If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: St John's College

FATHER
12. Name: Philip A. Regan
13. Birthplace: Fort Schuyler N.Y.

MOTHER
14. Maiden name: Laura A. Bright
15. Birthplace: Buffalo N.Y.

16. Informant: Philip A. Regan
Address: 930 Madison St. Washington D.C.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 25th 1940
(month) (day) (year)

Cemetery or crematory: May 25 1940

Location: Washington D.C.

18. Funeral director: W. W. Chambers
Address: 1400 Chapin St. N.W. Washington D.C.

19. May 25 1940
(Date rec'd by registrar)
J. J. Murphy
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1940, at 11 35 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ Post-mortem examination ~~19~~ ~~[illegible]~~ May 25 1940.

Immediate cause of death: Drowning

Due to: jumping off boat that was filling with water

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: May 25 1940

Where did injury occur? Bay Ridge (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?): Lake Ogleton

Means of injury: — — — Injured at work? no

23. SIGNATURE: John M. Claffy Deputy medical examiner
M. D. or other

Address: Annapolis Date signed: 5/25/40

RECEIVED
MAY 30 1940
BUREAU V. S.

15 Bal
05140

STATE OF MARYLAND—CERTIFICATE OF DEATH

(94-a)

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23

Village or City Brooklyn Pk. No. 805 Annapolis Rd. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John B. Rossman If U. S. Veteran, specify WAR

(a) Residence: No. 805 Annapolis Rd. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna Lee Barnes

6. DATE OF BIRTH (month, day, and year) Nov. 19, 1864

7. AGE Years 75 Months 5 Days 14 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Shop Worker B+D

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Md.

FATHER

13. NAME George Rossman

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Eva ?

16. BIRTHPLACE (city or town) Germany (State or country)

17. INFORMANT Mrs. J. B. Rossman (Address) 805 Annapolis Rd.

18. BURIAL, CREMATION, OR REMOVAL Place Holy Cross Date 5-7-40, 19

19. UNDERTAKER J. F. McCully (Address) 130 E. Fort Ave.

20. FILED May 5, 1940 Mrs. DeAlba Dep Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 3, (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1935, 19, to May 3, 1940

I last saw him alive on May 2, 1940; death is said to have occurred on the date stated above, at 4:00 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	5-2-40
Myocardial Degeneration	1938
Arteriosclerosis	1936

Other Contributory Causes of Importance:

Name of operation — Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Lawrence M. Serra M. D.

(Address) 1009 Annapolis Blvd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 1, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED MAY 7 1940 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (61)

05141

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency hospital
Stay in hospital or inst. (yrs., or mos., or days): 9 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Rural near Mayo Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mr. John H. Sauers Sr.
3. (b) Social Security Number: 218-01-9444 (Rose)

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bertha V Sauers
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Apr 12 1875
8. AGE: Years 65 Months 1 Days 6 If less than one day ____ hrs. ____ min.
9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business
FATHER 12. Name: John Sauers
13. Birthplace: Unknown Unknown
MOTHER 14. Maiden name: Margaret Sauers
15. Birthplace: Unknown
16. Informant: Bertha V Sauers
Address: Mayo P.G. Area Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20 40 (month) (day) (year)
Cemetery or crematory: U.S. National
Location: Baltimore
18. Funeral director: Wm Cook
Address: 1217 St Paul St
19. 5-19 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1940, at 11 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1940, to May 18 1940, and that I last saw him alive on May 18 1940.

Immediate cause of death	DURATION
Arteriosclerotic heart disease. Heart block	9 days
Due to	
Due to	
Other conditions: Diabetes mellitus	2 yrs.

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: W. F. Fidler M. D. or other
Address: Davidsonville, Md Date signed: 5-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 23 1940
BUREAU P. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1107

CERTIFICATE OF DEATH

05142

Reg. Dist. No. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: South River Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Chesapeake Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Raymond Frank Seeger

3. (b) Social Security Number 214-05-4036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1920

8. AGE:

Years	Months	Days	If less than one day
19	8	-	hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Baker
11. Industry or business Krigs Bakery
FATHER 12. Name Frank Bohle
13. Birthplace Unknown
MOTHER 14. Maiden name Nettie May Myers
15. Birthplace Balto Md.
16. Informant Guy Rosati
Address Chesapeake Ave. Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15th 40 (month) (day) (year)
Cemetery or crematory St Mary's Cem't.
Location Annapolis Md
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 5 15 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1940, at 9:30 M

21. I CERTIFY that death occurred on the date above stated: Post mortem examination
May 13 1940.

	DURATION
Immediate cause of death Fractured skull	
Fractured neck	
Due to Fracture both jaws.	
Due to Collision of truck and automobile on South River Blvd. 2 miles north	
Other conditions of South River Bridge	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 5/13/40
Where did injury occur? Highway #2 Parole Anne Arundel Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway #2
Means of injury auto collision Injured at work? No.

23. SIGNATURE John M. Coffey Deputy Medical examiner
M. D. or other
Address Annapolis Md Date signed 5/14/40

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 05143

1. PLACE OF DEATH:

County: Anne Arundel

City or town: East Port

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: East Port Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 2d St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie Shaw

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband: John Shaw

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): Aug. 20 1872

8. AGE: Years 66 Months 2 Days If less than one day ... hrs. ... min.

9. Birthplace: Smithville Calvert Co. Md (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER

12. Name: Benjamin Harod

13. Birthplace: Washington D.C.

MOTHER

14. Maiden name: Margarete Iffer

15. Birthplace: Smithville Md Calvert Co.

16. Informant: Sarah Crowner

Address: 602 East Port Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16 1940 (month) (day) (year)

Cemetery or crematory

Location: Churchton Aa

18. Funeral director: Charles H. Alexander

Address: 43-45 Northwest St Annapolis Md.

19. 5/14 1940 (Date rec'd by registrar) J J Murph Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th 1940 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7th 1940, to May 13 1940 and that I last saw her alive on May 12th 1940

Immediate cause of death: Myocarditis — DURATION: 1 rok

Due to: apoplexy & H.B.P. — 6 roks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J T Russell M.D. M. D. or other

Address: East Port Md Date signed: 5-14-40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

05144

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Drury Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A. A.

City or town: Drury Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: (Still Born) Smith

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: col

6. (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 11, 1940

8. AGE: Years | Months | Days | If less than one day: ~~May~~ Born dead hrs. min.

9. Birthplace: Drury Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Emory Smith
13. Birthplace: Bristol Md

MOTHER
14. Maiden name: Alice Gollers
15. Birthplace: Bristol Md

16. Informant: Emory Smith

Address: Bristol Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 5/12/40 (month) (day) (year)

Cemetery or crematory: Whittington's Cemetery

Location: Drury — Md

18. Funeral director: Emory Smith

Address: Drury — Md

19. 5/12 1940 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1940, at 11-40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Born dead

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Kennedy Lassen M. D. or other

Address: Upper Marlboro Md Date signed: 5/12/40

RECEIVED
JUN 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 05145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 6 months, 27 days
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 712 N. Caroline Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: BERTHA SMITH (Green)

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6 (b) Name of husband or ~~wife~~: Clarence Smith
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
38	Unknown		---- hrs. ---- min.

9. Birthplace: Unknown St Marys Co
(Town, county, and state)
10. Usual occupation: Unknown Housewife
11. Industry or business: ----

FATHER
12. Name: Unknown Aquilla Green
13. Birthplace: Unknown St Marys Co

MOTHER
14. Maiden name: Unknown Celie Mason
15. Birthplace: Unknown St Marys Co.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 14 1940 (month) (day) (year)
Cemetery or crematory: St George
Location: St Marys Co Md
18. Funeral director: Robert E. Williams
Address: 15-16 McElderry St

19. 5/11/40 (Date rec'd by registrar) E.F. Joy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10th 1940, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 13th 1939, to May 10th 1940, and that I last saw her alive on May 10th 1940.

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Syphilis	
Other conditions -----	

(Include pregnancy within 3 months of death)
Major findings: ----
Of operations:
Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ---- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury: Injured at work? -----

23. SIGNATURE: Herbert T. Smith M. D. or other
Address: Crownsville, Maryland Date signed 5/10/40

RECEIVED
MAY 17 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05146—

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 14 yrs. 7 mos. 10 das.
Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: JULIA SMITH

3. (b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6 (b) Name of husband or wife: --------
6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 56 | Months: Unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal, Which?) Burial Date thereof 5/15-40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt
Address

19. (Date rec'd by registrar) May 15 19 40 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 19 40, at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2nd 1925, to May 12th 1940, and that I last saw her alive on May 12th 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to	
Due to	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings: -----
Of operations:
Of autopsy: -----

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: Injured at work? -----

23. SIGNATURE: Herbert Snowden M. D. or other
Address: Crownsville, Maryland Date signed 5/12/40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

05147

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) life
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Annapolis Md. Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 44 State Circle
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Amanda Terry Strange

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John F. Strange
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th 1860

8. AGE: Years 80 | Months 11 | Days 18 | If less than one day hrs. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Thomas Sall Terry
13. Birthplace Annapolis Md.

MOTHER
14. Maiden name Mary Hubbard
15. Birthplace Annapolis Md.

16. Informant Mabel S. Richardson
Address 44 State Circle Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31/1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff
Location Annapolis Md

18. Funeral director John W. Taylor
Address Annapolis Md.

19. May 31 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29th 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1940, to May 29 1940, and that I last saw h[illegible] alive on May 29 1940.

Immediate cause of death Uraemia (Coma) — DURATION 24 hrs.
Due to Cr. Nephritis — 5 yrs.
Due to Arterial Hypertension — about 4 yrs or more
Other conditions C. Myo Carditis

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Oliver Parran M. D. or other
Address Annapolis Md. Date signed May 31/40

RECEIVED
JUN 5 1940
BUREAU V. S.

05148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 years, 10 months

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1437 E. Monument Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: JULIA THOMAS

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6 (b) Name of husband: ~~XXXX~~ Unknown

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1886 (?)

8. AGE:

Years	Months	Days	If less than one day
54?	Unknown		____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: General

FATHER
12. Name: Luther Forest
13. Birthplace: Maryland

MOTHER
14. Maiden name: Polly Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 5/18/40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location:

18. Funeral director: Robert L. Young
Address: 804 E. Caroline St

19. May 14 (Date rec'd by registrar) 1940 27 Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13th, 1940, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14th 1936, to May 13th 1940, and that I last saw her alive on May 13th 1940.

Immediate cause of death: General paralysis of the insane

Due to:

Due to:

Other conditions: Syphilis

(Include pregnancy within 3 months of death)

Major findings:
Of operations: -----
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work? ----

23. SIGNATURE: Robert L. Winterrode M. D. or other

Address: Crownsville, Md. Date signed: 5/13/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

05149

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH

County: Anne arundel

City or town: Ferndale
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Ferndale Road.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 29 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Ferndale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Ferndale Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: WILLIAM H. THOMAS SR.

3. (b) Social Security Number: 12-24-36

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Oceola A

6(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): December 27, 1876

8. AGE: Years 63 | Months 4 | Days 13 | If less than one day ___ hrs. ___ min.

9. Birthplace: Hagerstown Md
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: Balto News Post

FATHER
12. Name: Christina Thomas
13. Birthplace: Germany

MOTHER
14. Maiden name: Louisa Lowman
15. Birthplace: Balto Md

16. Informant: Oceola A. Thomas

Address: Ferndale Rd Ferndale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13/40 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown Md

18. Funeral director: William Cook

Address: 1217 St Paul St

19. May 10 1940 (Date rec'd by registrar) M. DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1940, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1937, to May 10, 1940, and that I last saw him alive on May 10, 1940

Immediate cause of death: Arteriosclerosis — Onset 1937
Cerebral hemorrhage — May 9, 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry M. Moore M.D. (M. D. or other)

Address: Glen Burnie, Md Date signed: 5-10-40

RECEIVED
MAY 28 1940
BUREAU V. S.

05150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84c)

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Baltimore City Hospitals

Stay in hospital or inst. (yrs., or mos., or days): 9 days

Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 437 Orchard St.,
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR: -----

3. (a) FULL NAME: JOHN THOMPSON

3. (b) Social Security Number: ------

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -------

6(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1921

8. AGE: Years: 19 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Clara Thompson
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 21, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cemetery

Location: Baltimore, Md.

18. Funeral director: A. Halstead

Address: 918 Druid Hill Baltimore, Md.

19. 5/18 1940 (Date rec'd by registrar) E. J. Joyce D.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16th 1940, at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7th 1940, to May 16th 1940, and that I last saw him alive on May 16th 1940.

Immediate cause of death: Manic exhaustion

Due to:

Due to:

Other conditions: Manic depressive psychosis/
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ------
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: Injured at work?

23. SIGNATURE: Herb P. McKrodz M. D. or other

Address: Crownsville, Maryland Date signed: 5/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05151

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (2)

County Anne Arundel Registration Dist. No. 20

Village or City Greenoth No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME (baby girl) Wallace If U. S. Veteran, specify WAR

(a) Residence: No. Greenock Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR ~~DIVORCED~~ (write the word)
female	negro	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6. DATE OF BIRTH (month, day, and year) May 13, 1940

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	Stillborn		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) A. A county
(State or country)

FATHER

13. NAME Snowden Wallace

14. BIRTHPLACE (city or town) Maryland
(State or country)

MOTHER

15. MAIDEN NAME Sophie Easton

16. BIRTHPLACE (city or town) Maryland
(State or country)

17. INFORMANT Father
(Address)

18. BURIAL, ~~CREMATION~~, OR REMOVAL
Place Home of S. Wallace Date 5/14, 1940

19. UNDERTAKER Snowden Wallace
(Address) Greenock Md

20. FILED 5/13, 1940 H. P. Clayton. Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 13, 1940
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 ; to , 19

I last saw h alive on Stillborn, 19 ; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Strangulation	
Birth Asphyxiation	
Dr. last called for 1½ after beginning	
Other Contributory Causes of Importance:	
Of birth	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicida, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Emily H. Nelson M. D.

(Address) Lothian Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05152

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 6 mos. 17 das
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ------

3. (a) FULL NAME: CLARA WASHINGTON

3. (b) Social Security Number: Unknown

4. Sex: Female
5. Color or race: black
6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: ------
6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 30 Months: Unknown Days: If less than one day: ____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: ----

FATHER
12. Name: Henry Washington
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lizzie Fowler
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5 (month) 31 (day) 40 (year)
Cemetery or crematory: Hampden
Location: Va

18. Funeral director: Charles H. Alexander
Address: 43-45 Northwest st. Annapolis Md.

19. 5 31 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30th 1940, at 8:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M. Nov. 12th 1937, to May 30th 1940 and that I last saw her alive on May 30th 1940.

Immediate cause of death: Pulmonary tuberculosis (both lungs)
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings: ------
Of operations:
Of autopsy: -----

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of:
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: Injured at work? -----

23. SIGNATURE: Herb P. Hinkerodz M. D. or other
Address: Crownsville, Md. Date signed: 5/30/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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05153

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 75 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Odenton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John A. Watts

3. (b) Social Security Number: NONE

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: May D. Watts, Jane Pihler

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept 19 - 1862

8. AGE: Years 77 Months 8 Days 1 If less than one day ___ hrs. ___ min.

9. Birthplace: Odenton Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Peter Watts

13. Birthplace: Anne Arundel Co Md

MOTHER 14. Maiden name: Charlotte Anderson

15. Birthplace: Anne Arundel Co Md

16. Informant: May Watts

Address: Odenton Ma

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23 1940 (month) (day) (year)

Cemetery or crematory: Epiphany Cemetery

Location: Odenton Maryland

18. Funeral director: Chas. T. Evans Son Inc

Address: 118 N. Mt. Royal Ave.

19. May 20 1940 (Date rec'd by registrar) W. L. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 - 40 19 , at 10 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 36, to May 20 19 1940 and that I last saw him alive on May 20 1940

Immediate cause of death: Lobar Pneumonia

Due to

Due to

Other conditions: Cardio Vascular Renal Disease + Diabetes

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. W. R. Lipskey M.D. or other

Address: Odenton Md Date Signed May 20-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUN 6 1940
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05154

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(30b)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr. 6 mos. 10 days

Stay in this community (yrs., or mos., or days): ------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: At Large County:

City or town: Baltimore City Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3111 Barclay Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: Veteran World War

3. (a) FULL NAME: FRANK M. WEBB alias FRANCIS WEBB

3. (b) Social Security Number: ------

4. Sex: male

5. Color or race: black

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife: Eva Webb

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 41 Months: Unknown Days: If less than one day: hrs. min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Butler

11. Industry or business: ----

FATHER

12. Name: James Webb

13. Birthplace: Georgia

MOTHER

14. Maiden name: Parmelia Simmons

15. Birthplace: Georgia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/16/40 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem

Location: Catonsville Md.

18. Funeral director: Joseph D. Locke Jr

Address: 1304 N Central Ave

19. May 18 1940 (Date rec'd by registrar) E. F. Jones D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1940, at 9:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from P.M. November 2nd 1938, to May 12th 1940, and that I last saw him alive on May 12th 1940.

Immediate cause of death: General paralysis of the insane

Due to:

Due to:

Other conditions: Syphilis

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ----

Of autopsy: -----

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ---- Date of:

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work? -----

23. SIGNATURE: Herbert L. Woodrow M. D. or other

Address: Crownsville, Md. Date signed: May 12, 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

05155

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospt.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A A

City or town: Eastport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 525 Burnside St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Whelan

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: —

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12th 1940

8. AGE:

Years	Months	Days	If less than one day
		1	hrs. min.

9. Birthplace: Annapolis Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: James S. Whelan

13. Birthplace: New York

MOTHER — 14. Maiden name: Elizabeth M. Hodek

15. Birthplace: Balto Md

16. Informant: Jas. S. Whelan

Address: Eastport Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 14-40 (month) (day) (year)

Cemetery or crematory: St Mary's Cem.

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 5 14 1940 (Date rec'd by registrar) J. J. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1940, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1940, to May 12 1940, and that I last saw h CR alive on May 12 1940.

	DURATION
Immediate cause of death:	
Due to: Atelectasis	
Due to: Ickthyosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Eastport Md Date signed 5-13-40

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JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05156

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Crownsville State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 yr. 10 mos. 9 das.
Stay in this community (yrs., or mos., or days): -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1009 McDonough Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: Unknown 216-10-4162

3. (a) FULL NAME: GRANT WILSON

3. (b) Social Security Number: ~~Unknown~~ 216-10-4162 (Poss)

4. Sex: male
5. Color or race: black
6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1902 (?)

8. AGE: Years: 38 ? Months: Unknown Days: If less than one day: ___ hrs. ___ min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ------

FATHER
12. Name: Gaird Wilson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Harriett (Unknown)
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 5/9/40 (month) (day) (year)
Cemetery or crematory: Burial-Mt. Calvary
Location:

18. Funeral director: Robert L. Young
Address: 804 N. Caroline St.

19. May 6 1940 (Date rec'd by registrar) E. F. Joyce D.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 1940, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27th 1938, to May 5th 1940, and that I last saw him alive on May 5th 1940.

Immediate cause of death: Pulmonary tuberculosis

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations: -----
Of autopsy: -------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: -------
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: Injured at work? -----

23. SIGNATURE: Joseph P. Mintzrodz M. D. or other
Address: Crownsville, Maryland Date signed: 5/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

05157

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Idlewild Shady Side P.O.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Idlewild

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Shady Side P.O. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Idlewild
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Goodloe Earle Yancey

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Marion Bond Yancey

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 9, 1874

8. AGE: Years: 65 Months: 10 Days: — If less than one day: hrs. min.

9. Birthplace: Cottage Mills Georgia
(Town, county, and state)

10. Usual occupation: Retired Govt. clerk

11. Industry or business: U. S. Govt

FATHER
12. Name: Dalton Hage Yancey
13. Birthplace: Alabama

MOTHER
14. Maiden name: Hetty McCook
15. Birthplace: Alabama

16. Informant: Mrs. M. B. Yancey

Address: Idlewilde, Shady Side, Md

17. Cremation Wash. Date thereof: May 9 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Crematory at Lees

Location: establishment Wash D.C.

18. Funeral director: J. Wm Lees Sons & Co.

Address: 300 - 4th N. E. Wash. D.C.

19. May 9 1940 (Date rec'd by registrar) D B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1940, at 12:05 AM

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination 19 ,
~~and that I last saw him alive on~~ May 9 1940

Immediate cause of death: Coronary Occlusion — DURATION: sudden

Due to: Arterio-sclerosis — 8 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings: —

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: John M. Caffy Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed: 5/9/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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STATE OF MARYLAND—CERTIFICATE OF DEATH

05158

1. PLACE OF DEATH (93d)

County Anne Arundel Registration Dist. No. 23

Village or City Roland Terrace No. Magie St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. 5 mos. ___ ds. How long in U.S. if of foreign birth? 60 yrs. ___ mos. ___ ds.

2. FULL NAME Mary Zemaitaitis

(a) Residence: No. Magie St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of the late Anthony Zemaitaitis

6. DATE OF BIRTH (month, day, and year) Dec 5, 1862

7. AGE: Years 77 | Months 5 | Days 20 | If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. house work

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. at home

10. Date deceased last worked at this occupation (month and year) ___

11. Total time (years) spent in this occupation ___

12. BIRTHPLACE (city or town) (State or country) Lithuania

FATHER

13. NAME Peter Pucas

14. BIRTHPLACE (city or town) (State or country) Lithuania

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Lithuania

17. INFORMANT Mrs. Margaret Volney

(Address) Magie St. Roland Terrace A.A. Co

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date 5/28/, 1940

19. UNDERTAKER John J. Cowan & Son

(Address) 901 Hollins St.

20. FILED May 27, 1940 Mrs. DeAlba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 25th, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from June, 1936, to May 25, 1940

I last saw her alive on May 24, 1940; death is said to have occurred on the date stated above, at ___ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Myocardial Degeneration	1939
Hypertension before	1936?
Arteriosclerosis "	1936?

Other Contributory Causes of importance:

Senile Dementia	1939
Inanition	

Name of operation — Date of ___

What test confirmed diagnosis? Clinical Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ___

(Signed) Lawrence M. Serra M. D.

(Address) 1009 Annapolis Blvd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN